GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

Guardianship Routing and Approval Form

PART 1: INDIVDUAL'S INFORMATION ***(To be completed by Service Coordinator)***

Full Name:		**DOB:**
Status (circle all that apply):	**Evans** **High Risk/Benchmark** **Impending Medical Procedure** **Urgent Medical Care Needed** **Emergency Medical Care Needed** **Current Guardian/Decision-Maker Unavailable**	**If Other, please explain:**
Home Address:		
Home Phone #:		
Residential Provider:	**Contact Person:**	
Provider Phone #:	**Email:**	

PART 2: SERVICE COORDINATOR INFORMATION ***(To be completed by Service Coordinator)***

Name:	
Email:	**Supervisor:**
Phone:	**Supervisor Phone:**

PART 3: REASON FOR GUARDIANSHIP REQUEST ***(To be completed by Service Coordinator - Please address, as applicable: the client's capacity for decision-making, the client's ability to execute a durable power of attorney, the lack of an appropriate person to be authorized as a durable power of attorney, the presence or lack of an identified person to serve as guardian.)***

PART 4: TRACKING DATES: ***(Required fields are in bold)***

Action Steps	Initials	Date	Comments
1) Date SPC Division Identified Need for Guardianship ***(To be completed by Service Coordinator)***		**Mo/day/yr**	
1a) Date Affidavit Issues Escalated to Supervisor/OAG for Assistance ***(To be completed by Service Coordinator if appropriate)***			
2) Date Package Completed and Submitted to SPCD Director's Office for Review			
2a) Date Package Returned to Program Manager for Correction			
2b) Date Corrected Package Resubmitted to SPCD, Director's Office			
3) Date Package Submitted to OAG			
3a) Date Package Returned by OAG to SPCD for Correction			
4) Date Package Accepted by OAG			